TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
COREY W. SKINNER, DC

Respondent Name
COMMERCE & INDUSTRY INSURANCE

MFDR Tracking Number
M4-15-2594-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
APRIL 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to AIG on October 1, 2014, this request was in response to a nonpayment of the $901.76 for the FCE Designated Doctor Referred Exam performed on May 5, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Requestor's Supplemental Position Summary: "We received a partial payment of $622.94 on 5/18/2015."

Amount in Dispute: $278.82 ($901.76 - $622.94)

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "we are in the process of issuing payment."

Response Submitted by: AIG Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2014	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	$278.82	$176.10

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - M359-Time expended on or the number of Functional Capacity Evaluations has been exceeded.

- 129-Prior processing information appears incorrect.
- XF24-The Federal Tax ID Number entered on the billing form is invalid. Please return this form with the required information.
- 18-Duplicate claim/service.
- U301-This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice).

Issues

Is the requestor entitled to reimbursement for the FCE rendered on May 15, 2014?

Findings

This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204.

On the disputed date of service, the requestor billed CPT code 97750-FC.
The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed".

28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

Per 28 Texas Administrative Code §134.204(g) to determine the reimbursement for FCEs the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

Per 28 Texas Administrative Code §134.203(c)(1)(2), the following formula is used to calculate the Maximum Allowable Reimbursement (MAR): (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = MAR.

The 2014 DWC conversion factor for this service is 55.75.

The Medicare Conversion Factor is 35.8228.

Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75075 which is located in Plano, Texas; therefore, the Medicare locality is "Rest of Texas."

The Medicare participating amount for CPT code 97750 is $32.09.

Using the above formula, the MAR is $52.76 per unit. The requestor billed for 16 units; therefore, $49.94 X 16 = $799.04. The respondent paid $622.94. The difference between MAR and amount paid is $176.10. As a result, additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $176.10.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $176.10 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/14/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.